

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0037051</u></p> <p>Facility Name: <u>Glen Brook</u></p> <p>Address: <u>Route 45 North</u> <u>Vienna</u> <u>62995</u> Number City Zip Code</p> <p>County: <u>Johnson</u></p> <p>Telephone Number: <u>618-658-2005</u> Fax # <u>618-833-4993</u></p> <p>IDPA ID Number: <u>37-1272698001</u></p> <p>Date of Initial License for Current Owners: <u>08/08/95</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>James A. Keller</u> Telephone Number: <u>618-833-5070</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 829" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1283 678 1923 727">(Signed) _____ <u>April 26, 2001</u> (Date)</td> </tr> <tr> <td data-bbox="1283 727 1923 808">(Type or Print Name) <u>James A. Keller</u> (Title) <u>President/CEO</u></td> </tr> <tr> <td data-bbox="1150 829 1283 1040" rowspan="4">Paid Preparer</td> <td data-bbox="1283 829 1923 878">(Signed) _____ <u>April 26, 2001</u> (Date)</td> </tr> <tr> <td data-bbox="1283 878 1923 935">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1283 935 1923 1008">(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1283 1008 1923 1040">(Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ <u>April 26, 2001</u> (Date)	(Type or Print Name) <u>James A. Keller</u> (Title) <u>President/CEO</u>	Paid Preparer	(Signed) _____ <u>April 26, 2001</u> (Date)	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # ()
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<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																															
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	(Firm Name & Address) _____																																
	(Telephone) <u>()</u> Fax # ()																																

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Glen Brook# 0037051 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,647</u>			<u>5,647</u>	13
14	TOTALS	<u>5,647</u>			<u>5,647</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.70%

D. How many bed-hold days during this year were paid by Public Aid?

157 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/23/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 01/01/90 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Glen Brook

0037051

Report Period Beginning: 01/01/00

Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	19,233	1,113	710	21,056		21,056		21,056		1
2	Food Purchase		42,371		42,371		42,371		42,371		2
3	Housekeeping		3,488	12	3,500		3,500		3,500		3
4	Laundry	9,028	928		9,956		9,956		9,956		4
5	Heat and Other Utilities			7,921	7,921		7,921		7,921		5
6	Maintenance		910	3,755	4,665		4,665	3,293	7,958		6
7	Other (specify):* Trash Removal			589	589		589		589		7
8	TOTAL General Services	28,261	48,810	12,987	90,058		90,058	3,293	93,351		8
	B. Health Care and Programs										
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	63,995	3,657	447	68,099		68,099	815	68,914		10
10a	Therapy	58,148		550	58,698		58,698		58,698		10a
11	Activities		535	518	1,053	5,000	6,053		6,053		11
12	Social Services	18,601	179	2,173	20,953	(5,091)	15,862		15,862		12
13	Nurse Aide Training			183	183	(183)					13
14	Program Transportation			3,057	3,057	34	3,091		3,091		14
15	Other (specify):* Dental/DT Services			144,108	144,108		144,108	(142,800)	1,308		15
16	TOTAL Health Care and Programs	140,744	4,371	154,336	299,451	(240)	299,211	(141,985)	157,226		16
	C. General Administration										
17	Administrative	11,300			11,300		11,300	4,945	16,245		17
18	Directors Fees										18
19	Professional Services			20,720	20,720		20,720	(19,939)	781		19
20	Dues, Fees, Subscriptions & Promotions			1,565	1,565	36	1,601	(622)	979		20
21	Clerical & General Office Expenses		570	3,067	3,637	(36)	3,601	6,255	9,856		21
22	Employee Benefits & Payroll Taxes			20,528	20,528		20,528	2,638	23,166		22
23	Inservice Training & Education			25	25	183	208	10	218		23
24	Travel and Seminar			501	501	(34)	467		467		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,562	3,562		3,562	92	3,654		26
27	Other (specify):* Licenses			235	235	91	326	(91)	235		27
28	TOTAL General Administration	11,300	570	50,203	62,073	240	62,313	(6,712)	55,601		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	180,305	53,751	217,526	451,582		451,582	(145,404)	306,178		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Glen Brook

#0037051

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,131	3,131		3,131	12,494	15,625			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			910	910		910	9,956	10,866			32
33	Real Estate Taxes			5,260	5,260		5,260		5,260			33
34	Rent-Facility & Grounds			38,400	38,400		38,400	(38,400)				34
35	Rent-Equipment & Vehicles			83	83		83		83			35
36	Other (specify):* Prop. Replacement Tax			2,195	2,195		2,195	(900)	1,295			36
37	TOTAL Ownership			49,979	49,979		49,979	(16,850)	33,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,210	30,210		30,210		30,210			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			30,210	30,210		30,210		30,210			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	180,305	53,751	297,715	531,771		531,771	(162,254)	369,517			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Glen Brook# 0037051Report Period Beginning: 01/01/00Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,563	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(295)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(210)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,195)	36		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(143,008)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (139,145)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(23,109)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (23,109)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (162,254)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Glen Brook

ID# 0037051

Report Period Beginning: 01/01/00

Ending: 12/31/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Day Training	\$ (142,800)	15	1
2	Funeral Flowers	(91)	27	2
3	PAC Dues	(77)	20	3
4	Johnson County Chamber of Commerce	(40)	20	4
5				5
6				6
7				7
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88				88
89				89
90	Total	(143,008)		90

Summary A

0037051

Report Period Beginning:

01/01/00

Ending:

12/31/00

[illegible]

Summary B

Facility Name & ID Number	Glen Brook	#	0037051	Report Period Beginning:	01/01/00	Ending:	12/31/00
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Glen Brook

0037051

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James A. Keller	50	Mulberry Manor	Anna	Kel-Tech Mgmt. Co.	Anna	Bkeeping/Maint.
Norine J. Keller	50	Holly Hill	Anna	JR's Centre	Anna	DD Workshop
		Lincoln Square	Jonesboro	ILS, Inc.	Anna	PPO DD CILA
		Pilot House	Cairo	J & J Partners	Anna	Property/Lease
		Krypton	Metropolis	ILS Land Trust	Anna	Property/Lease
		Liberty House	Marion			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Building Lease	\$ 38,400	J & J Partners	0.00%	\$	(38,400)	1
2	V	32	Mortgage Interest		J & J Partners		9,956	9,956	2
3	V	30	Depreciation-Building		J & J Partners		5,931	5,931	3
4	V	19	Management Services	20,200	Kel-Tech Mgmt. Co.	25.00%		(20,200)	4
5	V	6	Maintenance		Kel-Tech Mgmt. Co.	25.00%	3,293	3,293	5
6	V	10	Nursing Wages		Kel-Tech Mgmt. Co.	25.00%	815	815	6
7	V	17	Administrative Wages		Kel-Tech Mgmt. Co.	25.00%	4,945	4,945	7
8	V	19	Legal & Accounting		Kel-Tech Mgmt. Co.	25.00%	261	261	8
9	V	21	Chemical/General Office Expense		Kel-Tech Mgmt. Co.	25.00%	6,255	6,255	9
10	V	22	Employee Benefits/PR Tax		Kel-Tech Mgmt. Co.	25.00%	2,638	2,638	10
11	V	26	Ins-Property/Liability/Auto		Kel-Tech Mgmt. Co.	25.00%	92	92	11
12	V	36	General Capital Expense		Kel-Tech Mgmt. Co.	25.00%	1,295	1,295	12
13	V	23	Employee Training		Kel-Tech Mgmt. Co.	25.00%		10	13
14	Total			\$ 58,600			\$ 35,481	\$ * (23,109)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James A. Keller	Owner/Admin.	Administrator	50.00	73,748	4	10.00	Administrator	\$ 11,300	17-6	1
2	Norine J. Keller	Owner	Officer/Director	50.00							2
3											3
4											4
5											5
6											6
7											7
8	Management Fee Allocation: Indirect Costs										8
9	Don J. Pippins							Administrator	873	19-6	9
10	James A. Keller							Admin/Clerical	8,820	19-6	10
11	Jacob L. Alley							Maintenance	3,065	19-6	11
12	Diana K. Alley							Nursing	815	19-6	12
13								TOTAL	\$ 24,873		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Glen Brook# 0037051

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Kel-Tech Management Co., Inc.Street Address 158 East Vienna StreetCity / State / Zip Code Anna, Illinois 62906Phone Number (618-833-5070Fax Number (618-833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	% of Total Mgmt. Fee	277,800	10	\$ 45,280	\$ 42,146	20,200	\$ 3,292	1
2	10	Nursing Wages	% of Total Mgmt. Fee	277,800	10	11,215	11,215	20,200	815	2
3	17	Administrative Wages	% of Total Mgmt. Fee	277,800	10	68,012	68,012	20,200	4,945	3
4	19	Legal/Accounting	% of Total Mgmt. Fee	277,800	10	3,591		20,200	261	4
5	21	Clerical/General/Office Expense	% of Total Mgmt. Fee	277,800	10	86,021	65,300	20,200	6,255	5
6	22	Employee Benefits/PR Tax	% of Total Mgmt. Fee	277,800	10	36,286		20,200	2,639	6
7	26	Insurance-Prop/Liab/Auto	% of Total Mgmt. Fee	277,800	10	1,261		20,200	92	7
8	36	General Capital Expense	% of Total Mgmt. Fee	277,800	10	17,809		20,200	1,295	8
9	23	Employee Training				135		20,200	10	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 269,610	\$ 186,673		\$ 19,604	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Anna National Bank		X	Auto Note (Client Transport)	\$690.00	09/17/98	\$ 24,824	\$ 6,038	09/17/01	0.0890	\$ 910	1	
2												2	
3												3	
4												4	
5	Mortgage Interest from Related Party (Schedule VII B, Line 32)										9,956	5	
	Working Capital												
6	James K. Keller	X		Working Capital		09/01/90	60,000	4,800				6	
7												7	
8												8	
9	TOTAL Facility Related				\$690.00		\$ 84,824	\$ 10,838			\$ 10,866	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 84,824	\$ 10,838			\$ 10,866	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Glen Brook**# **0037051** Report Period Beginning: **01/01/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	6,070	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	5,260	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(810)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	6,070	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	5,260	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	5,309	8		
	1996	5,299	9		
	1997	5,321	10		
	1998	5,214	11		
	1999	5,260	12		

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

A. Square Feet: 4,300

B. General Construction Type: Exterior Brick/Vinyl Frame Wood Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>73-ICF/MR</u>	<u>85,000</u>	<u>1989</u>	<u>\$ 18,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	85,000		\$ 18,000	3

Facility Name & ID Number Glen Brook

0037051

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1990	1990	\$ 220,501	\$ 5,513	40	\$ 5,513		\$ 57,885	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Grounds Work/Landscape			1990	2,156	108	20	108		1,134	9
10	Sidewalk/Driveway			1990	6,200	310	20	310		3,255	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 228,857	\$ 5,931		\$ 5,931		\$ 62,274	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 44,927	\$	\$ 2,334	\$ 2,334	10-20 yrs.	\$ 40,011	37
38	Current Year Purchases	727	727	73	(654)	5 yrs.	73	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 45,654	\$ 727	\$ 2,407	\$ 1,680		\$ 40,084	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Client Transport	1995 Ford Escort Wagon	1995	\$ 12,956	\$ 745	\$ 1,944	\$ 1,199	5	\$ 12,956	42
43	Client Transport	1999 Ford 15 Pass. Van	1998	26,717	1,659	5,343	3,684	5	13,358	43
44										44
45										45
46	TOTALS			\$ 39,673	\$ 2,404	\$ 7,287	\$ 4,883		\$ 26,314	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 332,184	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 9,062	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 15,625	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 6,563	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 128,672	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: T. Richard Mager, Trustee of Glen Brook Land Trust 91

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1990</u>	<u>16</u>	<u>01/01/91</u>	\$ <u>38,400</u>	<u>3</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>16</u>		\$ <u>38,400</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 83

Description: Water Cooler Rental

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 01/01/01

Ending 12/31/03

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/2001 \$ 38,400

13. 12/2002 \$ 38,400

14. 12/2003 \$ 38,400

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 90,855	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	66,457		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24		6
7	Other Prepaid Expenses	341		7
8	Accounts Receivable (owners or related parties)	38,680		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 196,357	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	66,278		16
17	Accumulated Depreciation (book methods)	(101,504)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Furniture/Fixtures	37,715		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,489	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 198,846	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,838	\$	26
27	Officer's Accounts Payable	20,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	6,399		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,070		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,195		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 37,502	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,206		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	N/P-James K. Keller	4,800		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,006	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 48,508	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 150,338	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 198,846	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 149,004	1
2	Restatements (describe):		2
3	1999 Cost Report, Under Reported Net Income	1,603	3
4	by \$1603 and Over Reported 1999 Expenses by Some		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 150,607	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	144,286	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	144,555	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (269)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 150,338	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 664,057	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 664,057	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,337	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,337	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Administrative Handling Fee	2,325	28
28a	Excess Reimbursement/CNA/Hail Damage	8,338	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,663	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 676,057	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	90,058	31
32	Health Care	299,451	32
33	General Administration	62,073	33
	B. Capital Expense		
34	Ownership	49,979	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	30,210	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 531,771	40
41	Income before Income Taxes (line 30 minus line 40)**	144,286	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 144,286	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Glen Brook# 0037051Report Period Beginning: 01/01/00Ending: 12/31/00

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	515	576	5,000	8.68	9
10	Activity Assistants					10
11	Social Service Workers	1,393	1,557	13,601	8.74	11
12	Dietician					12
13	Food Service Supervisor	1,987	2,107	19,233	9.13	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry	1,102	1,110	9,028	8.13	19
20	Administrator	208	208	11,300	54.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,526	1,610	30,000	18.63	28
29	Resident Services Coordinator	654	690	11,450	16.59	29
30	Habilitation Aides (DD Homes)	11,621	11,933	80,693	6.76	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,006	19,791	\$ 180,305 *	\$ 9.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	26	\$ 710	1-3	35
36	Medical Director	33	3,300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	440	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	550	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	23	805	12-3	45
46	Other(specify)				46
47	Psychologist	28	1,277	12-3	47
48	Dental	14	1,100	15-3	48
49	TOTAL (lines 35 - 48)	145	\$ 8,182		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name	Function	Ownership %	Amount	Description	Amount			Description	Amount						
James A. Keller	Owner/Admin.	50	\$ 11,300	Workers' Compensation Insurance	\$ 2,928			IDPH License Fee	\$						
				Unemployment Compensation Insurance	1,410			Advertising: Employee Recruitment							
				FICA Taxes	13,772			Health Care Worker Background Check (Indicate # of checks performed <u>3</u>)	36						
				Employee Health Insurance	1,430			Non-allowable Advertising	210						
				Employee Meals				IHCA Membership Dues	905						
				Illinois Municipal Retirement Fund (IMRF)*				Less PAC Dues	(77)						
				Cost Allocation to Related Party (Sch. VII)	2,638			Sam's Club	45						
				Hepatitis Vaccinations	140			Misc. Community Operating Dues	70						
				Officers Life Insurance	848			Johnson County Chamber of Commerce	40						
								Less: Public Relations Expense	(40)						
								Non-allowable advertising	(210)						
								Yellow page advertising	()						
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 11,300			TOTAL (agree to Sch. V, line 20, col. 8)				\$ 979			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Description				Amount				Description				Amount			
				\$				Out-of-State Travel				\$			
								In-State Travel				242			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$				Seminar Expense				225			
C. Professional Services															
Vendor/Payee	Type	Amount		Description	Line #	Amount									
Kel-Tech Mgmt. Co., Inc.	Mgmt. Services	\$ 20,200				\$									
Barnett & Levine, LLP	Accounting Services	475													
Feirich, Mager, Green, Ryan	Legal Services	45													
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 20,720				TOTAL				\$			

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number Glen Brook

STATE OF ILLINOIS

0037051

Report Period Beginning:

01/01/00

Ending:

Page 23

12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Assoc. \$905
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Glen Brook #0036384 01/01/95
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 30,210
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 85%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Glen Brook
2000 Cost Report
Schedule V
Reclassification Detail

Lines 11/12	\$5000	Reclass from Line 12 to Line 11 for Social Service Wages involving Activity Director functions.
Lines 12/27	\$91	Reclass from Line 12 to Line 27 for funeral flowers.
Lines 20/21	\$36	Reclass from Line 21 to Line 20 for Illinois State Police background checks.
Lines 13/23	\$183	Reclass CPR training and miscellaneous staff training to line 23. for habilitation training.
Lines 14/24	\$34	Reclass RN travel from seminar to Program transportation.

Glen Brook
2000 Cost Report
Schedule XIII
Explanation

There was no turnover of certified habilitation aides in 2000

Glen Brook
2000 Cost Report
Schedule XVII
Section E
"Other Revenue" Explanation

Line 28 \$2,325 was a handling or Administrative fee assessed to facility employees for excessive payroll advances, as defined in facility policy.

Line 28a \$8,338 Insurance settlement for hail damage to facility van. There was no facility expense to offset because ownership elected not to repair the van.

Glen Brook
2000 Cost Report
Schedule XVII
Line 41 – Federal Tax Return
Reconciliation

Amount shown on Line 21 of 1120-S	\$ 146,157.00
Amount shown on Line 41 of Schedule XVII	<u>144,286.00</u>
Difference	\$ 1,871.00

Reconciliation:

The following items were not included in the federal tax return as expenses.

A. Contributions	\$ 295.00
B. Officers Life Insurance	848.00
C. Section 179 Depreciation	727.00
D. Rounding of Numbers	<u>1.00</u>
	\$ 1,871.00

Glen Brook
2000 Cost Report
Schedule XX
Question 12

Glen Brook has one position where the same staff person performs both Social Service functions such as training in a 1 on 1 classroom setting and the same staff person also directs and carries out the facilities activity program. The activities require about 25%-30% of her time, therefore a percent of her gross wages are reclassified out of Social Service wages into Activity wages.